Billing for Non-Medicaid-Eligible Members

Providers should bill members or the members' commercial health insurance for any services that are not included in the Family Care benefit package.

Billing for Services Included in the Family Care Benefit Package

Providers should bill the Care Management Organization (CMO) for services included in the Family Care benefit package. Each CMO will determine the policies and procedures for billing services, including:

- Claim form and coding requirements.
- Billing deadlines.
- Coordination of benefits (commercial health insurance and Medicare).

Contact the appropriate CMO for more information on the required billing procedures. Refer to Appendix 1 of this guide for a list of CMO contacts.

Medicare Crossover Claims

Providers should bill Medicare prior to billing the CMO to obtain the necessary payment or denial information from Medicare. The crossover claim will go through the same steps as described under Medicare Crossover Claims in the Billing for Medicaid-Eligible Members chapter of this guide. All charges for non-Medicaid-eligible members that are automatically forwarded to Medicaid fee-for-service by Medicare are denied by Medicaid.

Providers do not need to wait for Medicaid fee-for-service to deny a claim before billing the CMO for services included in the Family Care benefit package.

Billing for Services Not Included in the Family Care Benefit Package

Medicaid fee-for-service *will not* reimburse services provided to CMO members who are not eligible for Medicaid. Providers should bill members or the members' commercial health insurance for any services that are not included in the Family Care benefit package. Refer to "Provisions of Non-Covered Services" in the "Service Information"chapter of this section for more information on non-covered services.

Member Payment for Services

No Copayment

Services included in the Family Care benefit package **do not** require a member copayment.

Member Cost-Share

As outlined in the Member Information chapter of this guide, the financial eligibility assessment determines if a CMO member is required to pay a monthly cost-share. The monthly cost-share is based on the member's income and assets and his or her monthly cost of care. The CMO may collect the cost-share amount or direct a specific provider to collect the amount.

Provider Appeals

Both providers who are affiliated and providers who are not affiliated with a CMO may file an appeal when they disagree with the CMO's payment/denial determination.

When a CMO denies a provider's claim, the CMO is required to send the provider a notice describing the appeal process, including specific deadlines which must be met at various points in the process. The CMO is also responsible for supplying the provider with instructions on filing an appeal with that CMO. Providers are required to file their first appeal to the CMO within 60 days of the initial payment/denial notice. The CMO has 45 days from the date of receipt of the appeal request to respond in writing to the provider.

If the CMO fails to respond within the 45-day time frame, or if the provider is not satisfied with the CMO's response, the provider may seek a final determination from the Department of Health and Family Services (DHFS). The provider has 60 days to file the appeal to the DHFS.

The DHFS has 45 days from the date of receipt of written appeals to make a decision. The DHFS' decision is final. The CMO is required to pay the provider within 45 days of the DHFS' decision, if applicable.

Refer to Appendix 3 of this guide for a list of CMO and DHFS provider appeal contacts.

Refer to Appendix 3 of this guide for a list of CMO and DHFS provider appeal contacts.